Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CLINICS OF NORTH TEXAS
RONALD C JONES MD
2800 ARMORY ROAD
WICHITA FALLS TX 76302

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-12-2813-01

MFDR Date Received

MARCH 2, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was filed within time limit. We filed the claim 11/17/2011 to our clearing house P2P and they printed and mailed the claim to SORM 11/23/2011. Printouts from our software and P2P are attached verifying the claim was filed in a timely manner."

Amount in Dispute: $185.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to the aforementioned rule the Office did receive a bill from this provider on 12/5/2011 in the amount of $185.00 for date of service 8/24/2011 which is 103 days from the date of service, minus 5 days for mailing as indicated by the provider this would make the bill being sent 98 days from date of service."

Response Submitted By: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2011	CPT Code 29105	$59.00	$ 59.00
	HCPCS Q4010	$126.00	$0.00
TOTAL		$185.00	$59.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §102.4(h), titled *General Rules for Non-Commission Communication*, effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
4. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, requires that in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be fair and reasonable.
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
7. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - Per Rule 133.20; A healthcare provider shall not submit a medical bill later than the 95th day after the date the services are provided.
   - Pursuant to the Act; Sec. 408.0272, provider's print screens' do not serve as proof of timely filing.

Issues

1. Were the services billed to the carrier timely?
2. Is the requestor entitled to reimbursement for CPT code 29105?
3. Is the requestor entitled to reimbursement for HCPCS Q4010?

Findings

1. Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code§102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   (1) the date received, if sent by fax, personal delivery or electronic transmission or,

   (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

   The requestor submitted reports that indicate the disputed bill was sent on November 23, 2011 at 7:47:22 AM. This date is within the 95 day deadline set out in Texas Labor Code §408.027(a); therefore, the Division finds that the disputed bills were submitted timely to the insurance carrier.

2. CPT code 29105 is defined as "Application of long arm splint (shoulder to hand)."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor)

X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 54.54.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76302, which is located in Wichita Falls, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Rest of Texas.

Using the above formula, the Division finds the MAR is $128.15. The requestor is seeking a lesser amount of $59.00; this amount is recommended for reimbursement.

3. HCPCS code Q4010 is defined as "Cast supplies, short arm cast, adult (11 years +), fiberglass."

28 Texas Administrative Code §134.203 (f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G) states the request for dispute resolution shall include: "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $126.00 for HCPCS code Q4010 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $59.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $59.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/30/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.